

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$193,826.34, for dates of service 08/01/01 and extending through 09/18/01.
- b. The request was received on 07/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. UB-92
 - c. TWCC 62 forms
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. TWCC 62 form
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/12/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/13/02. The response from the insurance carrier was received in the Division on 08/27/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of a Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

“According to Commission rule 134.401, ICD-9 codes ranging from 800.00 thru 959.50 shall be reimbursed at a fair and reasonable rate for the entire admission. As these codes are specifically carved out of the ACIHFG, it is out[sic]

understanding that These[sic] admits are not to be considered at the per diem rate. Accordingly this admit is not only a trauma but also falls within the stop-loss carve-out of over \$40,000.00 in billed charges. It is implied in the ACIHFG that although this is a trauma admit the fair and reasonable for this should be at least 75%, as it has billed charges over \$40,000.00. Per rule 134.401 stop-loss methodology-‘This stop-loss threshold is established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment of an injured worker.’ Rule 134.401 section c 6aiii, ‘if Audited Charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using the SLRF of 75%.’ Even though Trauma admits are carved out within the ACIHFG, we do not believe the commission intended for hospitals to be reimbursed at a level less than 75% for charges over \$40,000.00. The Acute Care Inpatient Hospital Fee Guideline clearly indicates TWCC has determined 75% as a fair and reasonable reimbursement for **unusually costly services** rendered to an injured worker.”

2. Respondent:

“The requestor has not shown that the fees paid to date fall below the statutory standard. It is the Carrier’s position that a party seeking recovery of medical fees from a workers’ compensation carrier under the Texas Workers’ Compensation Act has the burden of proof to establish by a preponderance of the credible evidence that the fees sought are allowable under the Act. It is equally applicable in this case, where the requestor has already received payment from the Carrier for the very same services for which it now seeks additional payment, that requestor has the burden of establishing by a preponderance of the credible evidence that the Carrier’s payments fall short of the fee payments required by §413.011, Tex. Labor Code, and that an additional, specified amount of money must be paid to reach the payment level established by §413.011.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 08/01/01 and extending through 09/18/01.
2. The Provider billed the Carrier \$470,141.04 for the dates of service 08/01/01 and extending through 09/18/01.
3. The Carrier made a total reimbursement of \$158,779.44 for the dates of service 08/01/01 and extending through 09/18/01.
4. The amount left in dispute is \$193,826.34 for the dates of service 08/01/01 and extending through 09/18/01.
5. The denial listed on the EOB is “M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B).”

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was \$470,141.04. Per Rule 134.401(c)(5), states: "Reimbursement for certain ICD-9 Codes. When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate:

(A) Trauma (ICD-9 codes 800.0-959.50."

Per the Texas Worker's Compensation Act and Rules §413.011:

"(d) Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Per Rule 134.401(c)(6), Rule states: ... "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate."

Commission Rule 133.307 (g)(3)(D) places certain requirements on the provider requesting reimbursement. The provider has not provided any documentation that demonstrates and justifies that the payment amount being sought is fair and reasonable.

The provider has submitted reimbursement data. The provider has submitted a table of reimbursements from other carriers that have the same ICD-9 code as the date of service in dispute. However, none of the amounts listed are close to the amount billed in this case. Also, it is not known how many days these other patients were in the hospital, nor the types of treatment received. This table indicates that the provider has received reimbursement from 76% to 100% of the billed amount.

This does not conform with the criteria in Sec. 413.011 (d). Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 16th day of September 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

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